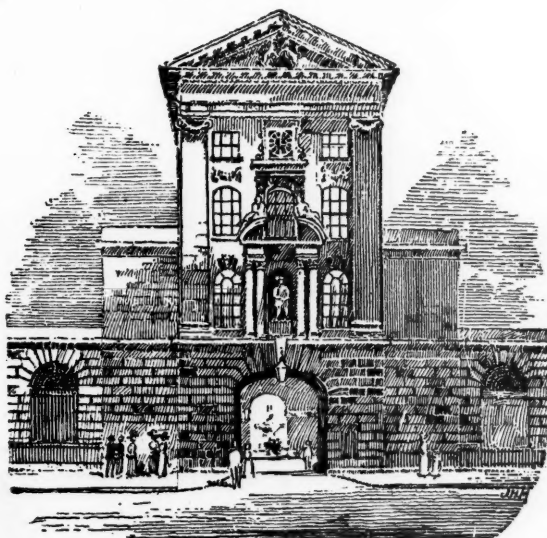


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# ST BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXIII.—No. II.

AUGUST, 1926.

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"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXXIII.—No. 11.]

AUGUST 1ST, 1926.

PRICE NINEPENCE.

### CALENDAR.

- Tues., Aug. 3.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
- Fri., „ 6.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
- Tues., „ 10.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
- Fri., „ 13.—Prof. Fraser and Prof. Gask on duty.
- Tues., „ 17.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
- Fri., „ 20.—Sir Thomas Horder and Mr. L. B. Rawling on duty.  
**Last day for receiving matter for September issue of the Journal.**
- Tues., „ 24.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
- Fri., „ 27.—Prof. Fraser and Prof. Gask on duty.
- Tues., „ 31.—Dr. Morley Fletcher and Sir Holburt Waring on duty.

### EDITORIAL.

**T**O those who are compelled to suffer London in August we offer our sympathy; we hope they may glean some comfort from the tiring reiteration of our newspapers that London has now become the summer resort of Europe, and although all good Americans may go to Paris when they die, yet they come to London in August to taste life at its brightest and best; for ourselves we find more consolation in the prospect of leaving it in September.

Meanwhile there are phantoms of delight to be enjoyed in August—among them the last, palpitating Test Match at the Oval, which threatens to outlast the patience of a crowd which finds its chief delight in the more rapidly moving forwards of Tottenham Hotspur.

Anyone strong enough to stand all night in a queue and sufficiently myopic to endure the squalor of the gasometers will probably have some excitement.

It is only necessary for the Australians to introduce a really good stonewaller like Mr. Charles Kelleway into the team to make certain of a riot.

\* \* \*

We are postponing the account of the Unveiling of the War Memorial by H.R.H. the Prince of Wales until the September issue.

The reason for this is that it is intended to send that issue to all old Bart.'s men the world over, so that, even if they do not subscribe to the JOURNAL, they may read of the ceremony and see photographs of the Memorial.

\* \* \*

We are reproducing, by the courtesy of the Editor of the *London Hospital Gazette*, a remarkable article, entitled "A Subjective Study of Encephalitis Lethargica." This article is of such unique interest that it deserves the widest possible attention.

\* \* \*

The Fleet Street Week Committee (with Lord Stanmore as chairman), which consists of influential men and women in the newspaper and commercial worlds, has been indefatigable in its labours. They have been very fortunate in securing the co-operation of the *Tatler* in their publicity and artistic adventures. It is hoped this year to overcome the previous tendency for the Week to be run by everyone but the inhabitants of Fleet Street, while contributions from every source are, of course, welcomed; Fleet Street is to be the centre of operation.

Fertile brains have devised, weighed and rejected many schemes, including banquets, treasure hunts and collecting races; sub-committees are sitting in secret, and a special edition of the *Westminster Gazette* has been

arranged for, to be on sale the whole week; 125,000 copies have been guaranteed and paid for. There are several notable contributors, but students of the Hospital are to be responsible for the four inner pages, so that anyone with a flair for exhibitionism or a love of charity may find an outlet for his personality. Contributions must be light even to frivolity.

Among the events that have already been fixed for the week are:

On Monday, October 11th, there is to be an Auction Sale at Bush House; on Tuesday, October 12th, there will be a collection by students in the city; and on the following Thursday and Friday there is to be a Bazaar at the Mansion House. We hope that every student will do all in his power to make the Week a success.

## A SUBJECTIVE STUDY OF ENCEPHALITIS LETHARGICA.

(By permission of the Editor of 'London Hospital Gazette'.)

**N**EUROLOGISTS have advised the writer that a subjective study of encephalitis lethargica would be helpful. A brief account of the illness will first be given; various manifestations will then be discussed.

A medical man, æt. 46, was attacked on the evening of January 17th with acute coryza. From the evening of the 19th he remained in bed for four days with pyrexia, which reached a maximum of 102° on the 20th. On the 21st and 22nd there was effortless morning vomiting, with hardly any nausea—a type which the patient considered cerebral. The pyrexia subsided, the patient got up on the 24th, and was at work again on Monday the 26th, though not feeling really well. Later in the week there was increasing weariness, which, however, could easily be overcome.

On Tuesday, February 3rd, a visual defect was noticed when backing his car; that evening there was marked diplopia and the patient felt very tired. Having had some experience of encephalitis lethargica, he was already in no doubt as to the diagnosis, but hoped the attack would be abortive. At 9 p.m. he retired, rather uncertain of the morrow, and awoke at 8 a.m. after a heavy but not dreamless sleep, feeling better, the diplopia no longer present for central vision. An ophthalmic surgeon examined the eyes on this morning (February 5th), and discovered bilateral paresis of the external recti. The night had been spent away from home, and after the eye examination, the patient, although heavy and tired, was able to see several patients and drive his

own car 63 miles. On reaching home he telephoned to a colleague and retired to bed.

Next day, and subsequently, paresis of accommodation developed with slight weakness of convergence, and the whole vision became misty. Drowsiness became more marked, with intervening restlessness; tremors, myoclonic movements, muscular inco-ordination and facial weakness supervened. An expert report on the condition about February 19th ran something as follows: "I found the patient with the typical Parkinsonian facies; he was very restless and extremely ill and weak." From this time recovery gradually took place; the patient left home early in May and returned to work on August 31st, not, however, absolutely well.

Now to consider the symptoms *seriatim*.

**Mental condition.**—Sleep and restlessness alternated, but drowsiness, sometimes intense, predominated. It was as if control had been removed, upsetting the rhythmic balance, which normally prevails, between sleep and wakefulness. One condition changed readily to the other; a word spoken, a door opening, sufficed fully to arouse the patient. The awakening was similar to that experienced when one goes to bed hoping to snatch some slumber before an inevitable night call; the call comes and you awake, expecting it, and with a certain alertness. The condition was accompanied by profound depression, naturally more marked during the restless intervals.

As soon as the eyes closed, if unconsciousness did not at once follow, the mind fell into a hypnogogic state and a variety of pictures and ideas succeeded one another. When awake it was sometimes difficult to sort out reality from imagery, and some confusion arose. For instance: Were the children away at school or at home? A moment's normal thought would show that they must be away, but in the patient's mind there was uncertainty.

The restlessness might well be called *impulsive restlessness*; it came on rather suddenly and sometimes subsided rapidly. It made the patient more than previously sympathetic with those cases of impulsive insanity which attain such medico-legal prominence. Suddenly he felt impelled to sit up, move about, get out of bed and walk. By an effort of will and some mental side-tracking the impulse could be overcome, but the effort needed was so great that it caused flushing of the face and sweating; then indeed the impulse might end in a desire to micturate, which compelled rising. The patient discovered that the best way to deal with the condition was to take a middle course permitting himself a little movement, such as sitting bolt upright or hanging the legs out of bed, but not rising or walking round the room. Apart from this feature self-control was normal and the patient could converse normally.



In every-day life we all have our days of hebetude, when we appear to ourselves exceptionally stupid, and also what I have called "mind pockets"; that is, when conversing, or perhaps speaking in public, the mind becomes suddenly blank, subject and argument alike forgotten. It is only momentary; a drink of water, or a cough, fill the gap, and the thread is resumed; but for a moment we have fallen into a "mind pocket." In this illness mind pockets and periods of hebetude became much more marked. The memory also was tricky, though this was often only a slowness in remembering, part of a general slowness of thought. Nevertheless, during the illness the patient wrote letters, drew up agenda for meetings, and was only for two or three weeks entirely divorced from mental activities.

There were also occasional aphasic tricks. For instance, speaking to his daughter about two friends seen passing on a tram—"I saw two of your schoolgirls on the top of the pram." The error was pointed out and the patient endeavoured to repeat the sentence correctly, but said the same again, and a conscious mental effort was necessary to get the right word. Another occasion when beginning a sentence there was no hesitation, but the same word was repeated several times, as "slim, slim, slim, slim," and then the sentence, the word "slim" having no obvious relation to the sentence.

*Dreams* deserve special mention. Amid a medley of incongruities, two types of dream are worth notice.

One I would call the *single image dream*; it occurred frequently at the height of the illness. The dreamer sees before him some simple picture; a head, a table, let us say, or a geometrical outline in black on a red ground; there is no action, just this image remains. Sometimes the head or figure might move a little, occasionally the picture changed to a more usual type of dream, but generally the image remained alone and unchanged.

The second type, which occurred twice, I would call the *apache dream*, and is also rather simple. The dreamer stands in a bare room in which there is another individual with his back towards him. To this stranger he bears the fiercest animosity and feels impelled to strike him violently, though there seems no reason whatever for such action. But the dreamer will not strike from behind, and waits, speechless with anger, until the stranger turns a leering, unpleasant face towards him, when he strikes violently and repeatedly with the greatest relief to his feelings—as much indeed as a long cool drink on a thirsty day. The room in which the encounter takes place is bare, the walls a pale terra-cotta colour, with a crude structure like a mantelpiece somewhere beyond the stranger on the left. To the dreamer this seems a kind of pagan altar.

Two other dreams may be mentioned, but they occurred during the patient's convalescence, and may have been related to his knowledge of the disease and not special manifestations.

One might be called a *larceny dream*. The patient is young again; he has obtained the key and opened the top of a pillar box. Inside are parcels, which he removes in order to show them to a younger brother; there is no thought of theft and no feeling of turpitude. Later in the dream he finds himself realizing that the action will be considered a theft, and schemes to avoid detection.

Another dream contained two rather brutal murders, not committed by the dreamer, but which are attributed to him. He has no feeling of horror at the crimes, only annoyance and anxiety at finding himself suspected.

Since the illness it has also been observed that dream characters speak more loudly than in the past.

Perhaps these dreams are worth recording, even at the risk of unpleasant interpretations by psychologists. Dreams may be regarded as babblings of the unconscious mind, and the study of them, especially of "common" dreams and those occurring in diseases or under special circumstances, may yet help us to sort out factors in psychology which will lead to a more accurate appreciation of mental conditions. Freud has focused our attention on dreams, but unfortunately it is mainly due to his influence that biased speculations have so largely replaced careful observations. Until some common cause can be discovered for common dreams (such as flying, falling, or the nightmare with cloying footsteps), the explanations remain, to me, unconvincing.

Concerning the two early dreams just narrated, the single image may have been due to sleepiness clogging the machinery of dreaming, or the dream may have originated at a lower brain level than normally. The apache dream suggests an emotional disturbance which did not reach the surface of every-day life.

Impulsive restlessness eased within four weeks; excessive drowsiness continued for about a week longer, but there have been occasional, more or less, transient recurrences.

*Eyes.*—The paresis of external recti cleared up in two weeks; the paresis of accommodation gradually improved, but some still remains, seven months after the onset. The mistiness of vision caused objects to appear as seen through a fog; it came on rather suddenly and cleared up within three months. A candle looked at through the fog would show four, or perhaps six images, suggesting to the patient a central defect rather than a local paralysis.

Before the illness, vision with the two eyes seemed equal, but now objects appear rather less bright with the left eye, and on waking especially, a slight, rather patchy

mist may be noticed in the left eye. At the height of the disease when the eyes were closed there once appeared to the left of the visual field a bright, rather square light, surrounded by a dark ring. This oscillated rapidly from side to side and then faded. The eyes were red and there was some itching of the lids soon after the onset. The orbicularis palpebrarum was weak; soap got into the eyes when washing and the lower lids sagged a little. There was also a good deal of rapid flickering of the orbicularis, especially noticed when closing the eyes to sleep.

*Muscles.*—Twitchings, tremors, inco-ordination, weakness and muscle pains were noted. With the facial muscles twitching was mainly on the left side, and involved chiefly lev. ang. oris, lev. lab. sup., and orb. palp. Tremors of the lips were so noticeable at the height of the disease that drinking terminated in a sound like "wow, wow, wow." There was also general weakness, so that at one stage the mouth dropped open during sleep, and whistling was almost impossible. This last has not yet completely recovered.

The *voice* deserves special mention. A feeling of constriction occurred as if someone were gently gripping the thyroid cartilage, and speech became increasingly difficult and uncomfortable, the sensation resembling that which accompanied a slight laryngitis. There was special difficulty in producing lower tones, but with an effort of will it was sometimes possible to speak normally. During one or two days words would not come in a stream, but singly, each one with an effort. These troubles passed in about three weeks, but have recurred transiently from time to time, mainly as a feeling of constriction and causing nothing that would be detected objectively.

There seemed at the height of the disease some disturbance of the *pharyngeal* mechanisms, and the patient was often roused from sleep by naso-pharyngeal secretion trickling into the larynx, and such actions as hawking seemed a little abnormal. The tongue also was tremulous when used within the mouth for a period of about ten days.

There were one or two gross *movements*, say of the forearm, when the disease was at its height, otherwise twitches have been mainly fibrillary or fascicular. The left forearm and right leg were mainly affected, but at one time there was a feeling as of a faradic current running over body and limbs. Later there were single twitches, or series of twitches, varying in strength, reminding the patient of morse signalling as heard by wireless, or by lamp, as seen at sea. Very many muscles were affected, but never the masseter or temporal muscles. Having once taught anatomy, the patient was interested to notice twitching of such muscles as

left tensor tympani, troublesome at one time, right posterior belly of omohyoid, right rhomboideus major, flexor brevis pollicis, coccygeus, and so forth. The twitching did not run the whole length of the muscle, but was felt almost exclusively at certain sites of election. In the triceps this was at the junction of the middle and lower thirds; latissimus dorsi at the level of the lower angle of the scapula; pectoralis major junction of middle and inner third; rectus femoris, femoral adductor group, tensor fasciæ femoris, gluteus maximus and sternomastoid all about the junction of middle and lower thirds, but the site in the left forearm extensor group was in their upper third. A second site in the triceps was very low down on the inner side, just above the epitrochlea, and there was a site very low down in the vastus internus to the inner side of the upper part of the patella.

Twitching was noticed during relaxation, and ceased when the muscle actively contracted, recurring sometimes when activity passed. On palpation the affected portion of the muscle was sometimes tender, but this was usually transient. The flickering did not affect function. Single twitches and morsing still occur, but are variable, being on some days practically absent, on others obvious.

*Tremors* were easily perceived at the height of the disease, but later might well be missed without special elicitation. Thumb and little finger were the chief offenders. To elicit the left thumb tremor, the patient holds the pronated hand in front of him, thumb hanging below an angle of 60 to the index finger; on gently raising the thumb towards the other fingers, keeping it slightly abducted, tremor might occur. In the right thumb, movements were brought out best by gentle cigarette-rolling movements over the outer aspect of the proximal phalanx of the index finger. Tremor of ring and little finger was usually induced by gently touching the tips of the fingers in succession with the tip of the thumb; on reaching the middle finger, ring and little fingers tremble; on proceeding to the ring finger the little finger movements increase. Or the arm may be held in front, hand loosely supinated, the fingers extended; the ring and little fingers are then flexed at the metacarpophalangeal and proximal interphalangeal joints, towards the position of a Dupuytren's contraction; tremor is induced. A left pronation tremor is best elicited with the patient on his back, hands above the head, palms uppermost; on gently increasing the pronation a left pronation tremor results.

The tremors were inconstant, but the exact conditions determining their presence were difficult to ascertain, especially as there has been a tendency to diminish. It was, however, noticed that they were more marked

on rising from an afternoon's rest, but quieted, or ceased, after moving about for a time. Excessive activity or excitement might cause them to return.

Some irritant lesion was suggested to the writer as the cause of the tremors, but it seems more likely that a partial nerve-block, rather like a heart-block, was present and hindered controlling impulses, which, fluctuating in strength as do most impulses, sometimes got through the blockage and at others failed.

Coarser movements occurred just before sleep. Most of us (all, perhaps, if carefully observed) have experienced a jerking of the limbs or body just before sleep, in the writer's case nearly always the sudden extension of one or both flexed limbs. It is as if the higher centres slept first, so removing control.

During this illness these "slumber jerks" became much more marked and varied. Flexion of a lower limb, movements of thumb or fingers, jerking of head or trunk might occur, and there was a tendency for muscles to jerk which had been specially used during the preceding day. One night, for instance, after some percussion, the right middle finger suddenly gave a spontaneous percussion movement, and there was on another occasion a curious jerk of the right arm slightly forwards and downwards, pectorals and latissimus dorsi both involved, which on reflection appeared similar to the initial action in starting a car; there was also a finger-and-thumb flexion which resembled the movements used in sounding the horn. The patient named these "twitch photographs." Analysis of other movements might have shown these also to be photographic.

I have watched a dog suffering from "chorea" after distemper, and the flexion and extension jerking of the limbs when the animal was half asleep were very similar to those observed in this case of encephalitis lethargica, and in no way resembled the familiar movements of rheumatic chorea.

**Pains.**—Slow, but transient, localized cramp-like pains occurred in the muscles. The whole muscle was very rarely affected, but only an area which felt about the size of a hen's egg, occurring generally, but not always, in the same vicinity as the twitches. The lower limbs were chiefly affected: quadriceps, calf, hamstrings and abductor groups, usually about the junction of middle and lower third. On palpating the muscle the affected portion was usually tender, and it was noticed, especially on the flexor aspect of the forearm, where the site was situated deeply between the bones at the junction of the middle and lower thirds, that pressure caused a return of pain after a long latent period of four to ten seconds.

There were also slow, transient, local, cutaneous pains, usually sharp, less frequently burning, and again chiefly

on the lower extremities. It was not a painful point, but an area, usually one inch in diameter, occasionally rather larger.

Slight *inco-ordination* was noticed, chiefly in complicated finger-movements. It was especially to be seen when the patient attempted a "scale," moving the fingers as if playing on the piano, synchronously with both hands, five notes in succession up and down. This could not be done; the right hand moved more quickly, while the left frequently played two notes simultaneously, and sometimes the fingers flexed and crumbled up. Later the left hand was noticed to miss out a finger from the scale, usually the ring or index finger. A movement of the right foot, as if to press the accelerator pedal of a motor car, was performed jerkily, and the same applied in placing the great and second toes of one foot on either side of the opposite tendo Achillis.

**Respiration** at the height of the disease was a little hurried, 24 to the minute, and seemed to patient rather deeper than normally. Now again, however, breathing became shallow and infrequent, giving the impression of a fitful and irregular Cheyne-Stokes' rhythm. About every 100 breaths there was a deeper sighing inspiration. To-day sighing is not noticeable, but undoubtedly more frequent than before the illness.

**Nails.**—If more clinical observation was devoted to the nails, our knowledge of medicine would probably increase. The difficulty is to be certain that the nail was smooth and normal before the illness: fortunately this patient had smooth and normal nails. The effect of the illness was to cause three transverse grooves, separated by an interval of about 1 mm., the last shallower than the two preceding. The whole nail texture below the first groove was thinner, and in some nails there was a little irregular pitting. The middle fingers showed the changes best, and the nail was affected for a distance of about 1 cm.

After concussion this same patient showed a deeper groove on all the nails; a gangrenous appendix caused a broader, shallower groove.

In another patient who attended periodically a series of meetings, entailing considerable mental exertion, it was noticed that the event was marked by a transverse row of white dots on some of the nails. This last observation needs confirmation, but, together with those previously mentioned, suggests that all body tissues react more swiftly and to a greater extent than is generally recognized to any disturbance of health.

**Infectivity.**—At the time the patient was attacked, the prevailing "influenza" epidemic was characterized by a rather sudden onset, with sickness, giddiness and pyrexia; it was described by one practitioner as "an epidemic of vomiting on the carpet." During the

patient's absence from home on the night of February 4th, a daughter, aged 8, slept in his bed, and exactly three weeks later she was suddenly attacked with dizziness, vomiting, pyrexia and a certain amount of lethargy. She recovered in a few days, but a week later developed acute otitis media and a mastoid operation was subsequently performed. Pyrexia did not at once subside, and there was a puzzling congestion round one or the other eye during the illness and subsequently. The patient's wife became affected with a similar "influenza" attack a few days after the child, which was followed by phlebitis, and about the same time an infant, aged 2, vomited rather violently on two successive days, and a third time two days later. In her case, however, there was no alteration in general health; even the appetite remained unaffected.

About three weeks before his January illness, the patient, late in the afternoon, when feeling tired, had seen a young woman suffering from an "influenza" attack accompanied by such prolonged drowsiness that encephalitis lethargica was suspected, but who subsequently made an uneventful recovery. It may be suggested that the patient with whom this paper deals was attacked with two symbiotic organisms, one paving the way for the other, and that the other patients avoided the symbiosis. But it seems simpler to suppose that all cases were due to one and the same agent, and that one of the many causes of the numerous epidemics labelled influenza which swept over the community, especially in the late winter and early spring, is the virus which occasionally gives rise to encephalitis lethargica. In epidemics accompanied by bronchitis, a few fulminating septicæmic pneumonias will be encountered, so it is not surprising that during epidemics in which cerebral symptoms predominate, a few instances of encephalitis may occur.

*Prognosis.*—As in most cases of encephalitis lethargica, this can best be summarized by a quotation: "Oh that a man might know the end of this day's business ere it comes; but it sufficeth that the day will end, and then the end is known."

Lubbock wrote that one of the "pleasures of being ill" was that it enabled the patient to realize and appreciate his friends. In case the Recording Angel forgets, my grateful thanks are due to many colleagues; to the Bart.'s man who treated the patient with untiring patience and kindness; to the expert (a "London" man) who travelled all night to be there at a critical time; to another old "Londoner" who read to the patient daily and without fail for three months; and to another "London" man who travelled 30 miles on two occasions to see if he could be of any help.

E. WARD.

## THE TECHNIQUE OF THE OPERATION OF GASTRECTOMY BY THE MOYNIHAN II METHOD.

**T**HERE are many methods of performing the operation of gastrectomy, but probably that of Moynihan is the safest and the easiest. Most gastrectomy operations are described as modified Polyas when, in reality, it would be more accurate to call them modified Bilioths. This surgeon performed the operation many years before Polya published his classic description.

The removal of the pylorus, or the pylorus and a portion of the stomach, is essentially the operation of Bilioth; but it is in the anastomosing of the duodenum, or jejunum, to the remaining portion of the stomach that individual surgeons have described modifications which bear their names.

In this article I will detail the operation as performed by Moynihan, but with certain differences in technique which, in my experience, are improvements on the method as originally described and practised.

*The incision.*—This should be generous, and should never be less than 5 in. As a rule it starts 2 in. to the right of the xiphi-sternal joint and proceeds vertically downwards to 2 or 3 in. below the umbilicus. The anterior sheath of the rectus is divided in the line of the skin incision, and the rectus muscle is dissected clear and retracted outwards. Before the peritoneal cavity is opened, tetra-cloths are clipped on to the skin edges.

The peritoneum is now freely incised, and soft, thin, pliable macintosh sheetings are fixed to the margins with large curved artery forceps before the exploration is conducted. A general systematic examination of each of the abdominal organs is the next step. The whole of the stomach must be examined. The lesser curvature in its whole extent, the greater curvature, the anterior and posterior surfaces, the pyloric and œsophageal regions must be seen and palpated.

The examination of the posterior surface of the stomach is best conducted through an opening made in the omentum just below the middle of the greater curvature. Through this opening the hand can be introduced, and this portion of the stomach can be brought into view.

The nature of the lesion, its position, size, shape, degree of fixation, etc., and the condition of the neighbouring lymph-glands are noted before deciding on the extent of the operation.

*Operation.*—A large Cripps's pad is placed behind the spleen to push the stomach forwards, and the right kidney pouch is packed off with a large strip of gauze



soaked in hot salt solution. The rent previously made in the great omentum is enlarged to the right and to the left, and the right and left gastro-epiploic arteries are clamped in two places, divided and tied off with No. 2, 30-day catgut. The thin, filmy middle portion of the gastro-hepatic omentum is torn through with the fingers, and the stomach is picked up about its middle and drawn through the wound.

Very often the stomach is adherent to the pancreas by a few weak adhesions, and occasionally it is firmly fixed by a large eroding ulcer. The weak adhesions are easily divided and do not in any way interfere with the operation. On the other hand, where the viscus is attached to the pancreas or liver by a large chronic ulcer, the operator proceeds to the next step in the operation, leaving this to be dealt with later on.

The pyloric artery is seized between two forceps and divided as close to the first part of the duodenum as is possible. The divided ends are tied off at once with stout catgut ligatures. The pyloric end of the stomach and the duodenum are now freed in their entire circumference from all their attachments. Two Payr's clamps are applied side by side and are made to crush the gut just distal to the pyloric opening. These clamps should be made a little larger, stronger (and without a terminal tooth), than those usually supplied. Large artery forceps which are occasionally used at this stage, and sometimes for enterectomies, are quite useless, as they are not hæmostatic and they are very poor crushers.

The duodenum is then severed between the clamps with a knife, and a macintosh swab is clamped over the divided pyloric end. The duodenum is closed with an "inverting" stitch of No. 00, 30-day chromic catgut, and a few reinforcing stitches of fine Pagenstecher thread are introduced here and there to strengthen the suture line. Further support is given to the suture line by the application of an "omental pad."

If the ulcer is firmly adherent to, or actually eroding, the pancreas, it is simpler and safer to cut it away from the stomach and leave it *in situ*. The base of the ulcer can be touched with pure carbolic, or with the actual cautery, but I have not found that it is necessary even to do this. If the ulcer is removed with a portion of adherent pancreas the dangers are twofold—hæmorrhage and pancreatic fistula. I have seen a case of acute hæmorrhagic pancreatitis occurring three days after a gastrectomy, in which the ulcer was removed in this way.

The ligation of the coronary artery may be one of the most difficult features of the operation. It must be tied as close to its origin as possible, and in order to simplify this, the stomach should be drawn downwards and rotated slightly inwards. If the artery is not seen, it

can at least be felt between the two layers of the gastro-hepatic omentum. The artery is sometimes embedded in a mass of inflammatory tissue and surrounded by numerous lymphatic glands. As soon as the artery is definitely identified and isolated, it is picked up and divided between two artery forceps and the ends tied off with strong catgut. The distal portion of the artery together with the lymph-glands and fat is swept downwards towards the lesion. This necessarily leaves a raw area high up on the lesser curvature, and it is important to cover this by drawing together the edges of the peritoneum with fine catgut before proceeding further.

As a rule, one removes two-thirds of the stomach, but in cases of large, doubtful ulcers, and in carcinoma of the pylorus and middle portion of the stomach, one excises considerably more according to circumstances. In a routine operation, all that remains of the cardiac end of the stomach is a fifth of the lesser curvature and two-fifths of the greater curvature. The glands along the lesser curvature and the majority of glands along the greater curvature together with a large part of the great omentum are taken away when the stomach is removed.

After high division of the coronary artery, 2 to 3 more inches of the stomach can be drawn through the wound. Using the stomach as a retractor, and pulling it downwards and inwards, a gastro-enterostomy clamp is applied to the cardiac pouch, some 2 to 3 in. below the œsophageal opening. This clamp, when in position, will be vertical, with the blades pointing towards the pubes. Parallel to, and  $1\frac{1}{2}$  to 2 in. distal to this clamp, a large Payr crushing clamp is applied. Below this Payr again another gastro-enterostomy clamp is applied, and the stomach divided between them and removed.

The Payr clamp in the remaining portion of the stomach is now rotated to the left, thus bringing the posterior surface of the stomach into view.

The duodeno-jejunal flexure is then sought for and identified; and a loop of jejunum some  $4\frac{1}{2}$  in. below this is brought over the transverse colon and applied to the under-surface of the stomach—the direction of the loop being from left to right. The portion of the jejunum to be anastomosed to the cut end of the stomach is seized with a gastro-enterostomy clamp. A peritoneal 00, 30-day chromic catgut stitch approximates the jejunum to the under-surface of the stomach about  $\frac{1}{2}$  in. proximal to the crushing clamp. One or two reinforcing fine Pagenstecher thread sutures are introduced here and there.

The Payr's clamp is then removed, and the crushed edges of the stomach are pulled apart by fine French

vulsella forceps. With a tenotomy knife the jejunum is incised parallel to the cut end of the stomach, and the incision is of the same length. Redundant mucous membrane of the jejunum is cut away, and the margins of the gut retracted with vulsella forceps.

The operation now proceeds as for a gastro-enterostomy, the inner stitch picking up all the coats and being of the ordinary "running" stitch variety. If a Connell stitch is used, it is important for the catgut to be thicker than the No. 00, 30-day. With the completion of the peritoneal stitch, the suture line is reinforced at its corners with a few fine Pagenstecher sutures. The remains of the great omentum are now brought over the stomach bed and affixed to the cut margin of the gastro-hepatic omentum. This manœuvre effectively smooths over the raw areas in this region.

The abdomen is closed in layers in the usual way, but before doing so the appendix is removed.

#### *Treatment of Ulcers high up on the Lesser Curvature.*

The operation of gastro-enterostomy is only occasionally successful for ulcers in this situation; excision is very often impracticable, cauterization of the ulcer is dangerous, and Braithwaite's cholecyst-gastrostomy is physiologically unsound. I have, therefore, abandoned these methods in favour of gastrectomy with excision of the entire lesser curvature of the stomach; and the results have been so gratifying that I consider it to be the operation of choice.

The technique is the same as that already described for gastrectomy with the following additions:

1. The stomach is removed 2 or 3 in. *distal* to the ulcer.
2. The remaining portion of the lesser curvature together with the ulcer is removed between two large curved crushing forceps.
3. The lesser curvature is reconstituted before proceeding with the anastomosis.

RODNEY MAINGOT.

### PROCTOCLYSIS IN THE TREATMENT OF SEPSIS AND POST-OPERATIVE COLLAPSE.



ISSUES which are either dehydrated or poisoned, or both, require large amounts of fluid.

In health, of food taken by the mouth, very little of the watery part is absorbed until the food reaches the colon. Man eats with his small intestine, but drinks with his large bowel.

When, for any reason, a patient is unable to take sufficient liquid by mouth, copious amounts of fluid can be supplied *per rectum*.

Saline solution, when run slowly into the rectum, is carried back into the colon, probably by anti-peristalsis and by the ascending mucous currents, described in 1906 by C. J. Bond, and absorbed by the colon.

Almost any drug which is soluble in water can be given in the saline solution.

Over twenty years ago the late Dr. John B. Murphy, of Chicago, described his method, known in America as "the Murphy drip," by which a patient is enabled to absorb quickly *per rectum* large quantities of saline solution.

Many faulty methods have been described as that of Murphy, who himself wrote: "We have visited hospitals numbers of times, and have been shown patients who were receiving the 'Murphy treatment.' We should not have recognized it without the label."

Moynihan (1), writing on proctoclysis, says: "The mode of administration best adapted for the purpose is that originally introduced by Murphy; there have been several subsequent modifications by other surgeons, but no improvements."

The crowded curricula of students and nurses rarely include instruction in the essentials of Murphy's method of proctoclysis. Murphy's directions are that "the flow must be controlled by gravity alone, and never by a forceps or constriction on the tube, so that, when the patient endeavours to void flatus, or strain, fluid can rapidly flow back into the can, otherwise it will be discharged into the bed. It is this ease of flow, to and from the bowel, that insures against over-distension and expulsion on the linen."

The elaborate machines in which the rate of flow is regulated by a "dropper," tap, or clip, limit the amount of fluid which reaches the rectum in a given period of time, and prevent the patient from straining fluid and flatus back into the reservoir.

No form of apparatus is suitable unless it provides for a free passage from the rectum to the reservoir, and also for a further supply of the solution to the rectum, as soon as the fluid already in the rectum has been absorbed.

*Apparatus.*—The simplest and best apparatus is an ordinary douche-can, of capacity at least a quart, without a tap, and carrying 5 ft. of rubber tubing, stout-walled to prevent kinking, and having an inside diameter of at least  $\frac{1}{4}$  in. At the end of the tubing is a soft rubber nozzle, in the bulbous end of which are several large holes. It is essential that these holes should be large and multiple, there being always a possibility that a single opening, such as the eye of a

rubber catheter, may become blocked either by a fold of mucous membrane or by a plug of fæces.

If, instead of the rubber nozzle, a rubber catheter is employed, it must be large, size No. 14-16 English gauge, and should have two extra eyes cut near its tip.

*The solution.*—The saline solution is made by dissolving one and a half drachms of sodium chloride (common salt) in each pint of warm water. Two pints of the solution, at a temperature of 105° F., are poured into the can to commence with. The solution will have cooled to about 100° F. by the time it reaches the rectum.

The can is covered with a bag, made of several layers of flannel to preserve the heat. For convenience in handling, the tube near the can may be occluded by a clip, *which must be removed before the administration is commenced.*

If the can is not graduated, strips of strapping are fixed horizontally on the outside of the can, to indicate the level of the surface of the solution, when the can holds respectively one and two pints.

*Administration.*—The patient, as a rule, will be in the "Fowler" position, but the method of administration is the same, whether the patient be propped up or lying on his back or on his side. In an operation case, the best time to commence the administration is as soon as the patient is back in bed, before he comes out of the anæsthetic. The can is filled with two pints of warm solution. A written account is kept of this, and of all subsequent amounts. After emergency operations, when it has been impossible to prepare the patient by emptying the lower bowel, the rectum, if found to be loaded with fæces, must be emptied by a simple enema before commencing the administration. The can is fixed, either to a bed-rail or on a stand or table, with its bottom 3 in. above the level of the top of the mattress. The rubber tube is laid on the sheet which covers the mattress, the nozzle being compressed between the nurse's finger and thumb. The end of the nozzle is held over a bowl, at the level which the nozzle will occupy when in the rectum, and a little of the solution is allowed to run into the bowl. (When estimating the amount of fluid absorbed, the few ounces lost in the bowl are deducted from the two pints in the can.) If the solution spurts out instead of just trickling from the nozzle the can is too high, and must be lowered until the solution slowly dribbles out. The rubber tubing must not dip below the top of the mattress. Then the nozzle, pinched between the finger and thumb, is inserted into the rectum until its tip is 3 in. above the anal margin. In ordinary cases the nozzle, being wet, is easily inserted. Should hæmorrhoids be present, the nozzle is lubricated with a thin oil. Vaseline is liable to block the holes in the nozzle

and should not be used. A large pad of absorbent wool, placed against the anus, prevents the nozzle from being expelled. As a further precaution, the tubing may be fixed to the thigh with strapping.

If, after fifteen minutes, no fluid has left the can, the can is raised for one minute by 2 in., in order to start the flow, and then replaced in its former position. If the fluid escapes through the anus, or if the patient complains of feeling blown out, the can is too high and must be lowered 1 or 2 in.

The flow from the can is not continuous, but repeatedly stops for some minutes and then starts again.

If at any time the can is found to be empty, the nozzle must be taken out of the rectum and the can and tubing refilled with solution before resuming the administration. If this is not done, the air which is in the tube may either be forced into the rectum, or, by remaining in the tube, prevent the solution from leaving the can.

Absorption of large quantities of saline solution causes copious secretion of urine, necessitating emptying of the bladder, either naturally or by catheter, at least every four hours. The administration can be continued for many hours on end. It is a good rule not to let the fluid in the can fall below the one pint mark, and when replenishing a pint at a time, to employ solution at 110° F., to compensate for the loss of heat in the solution remaining in the can. If the patient strains, some of the solution, often discoloured by fæces, together with flatus, passes back into the can. The discoloured solution needs removal only when solid fæces, large enough to partly obstruct the eyes of the nozzle, are present.

In regard to the amount which should be absorbed, no rate which is less than eight pints in the first twenty-four hours is satisfactory. Many patients, especially those who are both dehydrated and toxæmic, will absorb twelve or more pints in this time. For instance, a man, operated upon by the writer for a perforated duodenal ulcer with spreading peritonitis, at the end of the operation was collapsed, with a feeble pulse of 120 and a temperature of 95° F.

In the first thirty-six hours after operation twenty pints of saline solution were absorbed *per rectum*, bringing the temperature up to 99° F. and the pulse down to 90. Absorption of large quantities of fluid by a dried-up and poisoned patient gives him a sensation of well-being and relief from distressing thirst—benefits obtainable by no other treatment.

#### *Apparent Defects in Murphy's Method.*

1. The rate of flow from the nozzle will vary according to the height of the solution in the can. It does so vary,

but only by becoming slower, and, in practice, it is found that this slight diminution in the rate of flow is negligible.

2. The temperature of the solution, both in the can and in the rectum, tends to fall. It does, but, provided the temperature of the fluid in the rectum does not fall far below body-heat, absorption is unimpeded.

3. The patient will absorb too much and will become œdematous. The writer, in a twenty years' experience of Murphy's proctoclysis, embracing several hundred administrations, has looked constantly for such œdema, but has never found the slightest sign of it. He has seen œdema occur when saline solution has been given by other routes, notably the intra-venous. Moynihan (1), after referring to the possibility of throwing undue strain on damaged kidneys by absorption of more than twelve pints in twenty-four hours, says, "Nevertheless, in my own experience, nothing but good has resulted from this lavish administration of fluids; it is possible that the colon ceases to absorb so greedily when the needs of the body are satisfied." In this connection it should be remembered that, although twelve or more pints may be absorbed in twenty-four hours, at no one time do the patient's tissues contain this amount.

After the absorption of the first few pints the patient begins to get rid of fluid, and in septic cases of toxins, by the usual emunctories, especially the kidneys, while, in cases of peritonitis which have been drained, the peritoneum pours out fluid, in amount sufficient to repeatedly saturate the dressings. The details which ensure rapid absorption of large quantities of fluid are: (1) The provision of a free passage, from the rectum to the reservoir, for fluid and flatus, whenever the patient strains, and (2) the maintenance in the rectum of a small pool of saline solution, from which the colon takes frequent sips.

#### REFERENCE.

(1) MOYNIHAN.—*Abdominal Operations*, 4th edition.

C. HAMILTON WHITEFORD.

### 'GUY'S HOSPITAL REPORTS,' VOL. 76, NO. 2; 'ST. BARTHOLOMEW'S HOS- PITAL REPORTS,' VOL. LIX.

**T**HE opportunity for reviewing simultaneously numbers of the *St. Bartholomew's* and *Guy's Hospital Reports* is one of considerable interest. Comparisons are in several ways suggested. The former appears annually, and the latter is a quarterly

production. This difference invites the further comparisons respecting quantity and quality. One would desire to find that, quantity being equal, quality favoured the less productive volume by four to one!

A further point for reflection is the function of such reports in relation to the more widely read journals, such as the *Quarterly Journal of Medicine* and its surgical equivalent.

A worker whose conclusions are of general interest and likely to influence others interested in his subject should surely embody them in the periodical that will soonest catch the public eye. Interesting observations that are worthy of being put upon record, though their exact implication is not quite understood, can be housed safely in less wide-read leaves. They will then be ready for the correlator who is searching the literature for evidence upon some specific point. The two other worthy functions of a local scientific journal are the relation of matters of definitely local interest, and the opportunity to young writers of correlating observed facts and of reporting cases of interest. As stated in the foreword, the *St. Bartholomew's Reports* are, as far as possible, a record of the work going on at the Hospital.

There is a further function of more doubtful merit. Should a periodical be used by members of a school as a receptacle for work of first-class importance with the idea, whether admitted or tacit, of heightening the prestige and enlarging the influence of that school? One comes here upon the principle of competition as opposed to socialism. Competition would say, "Yes; for the keener our fight the better the results." Socialism would say, "No, for effort is wasted."

One certainly receives the impression that the *Guy's Hospital Reports* are largely—not of course entirely—an expression of the intense vitality and versatility of their brilliant Editor. The *St. Bartholomew's Hospital Reports* are less individualistic.

There is in each volume an "In Memoriam" notice. The loss of Guy's in the death of Dr. G. H. Hunt is the heavier, for he was only entering upon his best years, and the sympathy of St. Bartholomew's men will be extended to the sister hospital in her bereavement.

The scientific matter of the *Guy's Reports* includes a valuable posthumous article upon heart disease and pregnancy by Dr. Hunt. The bearing upon the added risks during pregnancy of valvular disease, with and without enlargement, and of auricular fibrillation is carefully analysed for a series of 156 patients. The presiding genius of Dr. Hurst is manifest in a valuable series of articles describing digestive and eliminative subjects. A case of achalsia of the cardia, with histology, is fully described by Dr. Pake, a case of posterior



pharyngo-oesophageal pouch with the surgical treatment by Mr. Tanner, and a valuable series of cases of duodenal ileus by Dr. Hurst, Mr. Rowlands, Mr. Gaymer Jones and Dr. Ryle.

Mr. Rowlands describes the technique of enterostomy for acute obstruction of the small intestine, and Dr. Kyle gives a clear clinical picture of the condition of "ball-valve" accumulations in the rectum. The concentration of salicylates in the bile, as obtainable by experimental dosage of animals by mouth, is investigated by Dr. Knott, and finally there is a lengthy and comprehensive chapter on tumour-formation by Dr. G. W. Nicholson.

The contents of the *St. Bartholomew's Hospital Reports* begin with a most interesting historical account of the rebuilding of the hospital in the eighteenth century by Sir D'Arcy Power, complete in its circumstantial detail. This is followed by Prof. Fraser's report to the Rockefeller Foundation upon the teaching of clinical medicine in medical schools in America. It is chiefly valuable in emphasizing the fact that with the progress of science, schools will more and more tend individually to cater for different types of medical men—one to produce general practitioners, one to produce the research worker and the consultant. Many of the present difficulties seem due to the all-embracing nature of the curriculum. A valuable analysis of the results of the operative treatment of perforation of gastric and duodenal ulcers, by Mr. Girling Ball, lays emphasis upon the supreme importance of early diagnosis, and suggests that where possible local treatment of the ulcer should be accompanied by gastro-enterostomy. Full case-reports are appended. Dr. Hopwood writes an illuminating article upon the basis of light therapy from the point of view of its physics, and Mr. Elmslie upon treatment of intracapsular fracture of the femur. The notes, by Dr. Twort, upon immunity and specific therapy in tubercular disease have the great merit of independence of thought. They emphasize the importance of a fundamental knowledge of the physiology, chemistry and animal pathology of acid-fast bacilli to workers who hope to try out successfully any new remedy in tuberculosis. Certain valuable basic principles are enunciated. Dr. Langdon Brown deals, in his usual fascinating manner, with the life-history of hæmoglobin in the body, with its clinical bearings.

The remarks of Sir Thomas Horder upon Vaquez disease and its complications, with notes of seven cases, constitute a very full and valuable contribution to the clinical symptomatology of the condition. He combines as usual clarity of style with clarity of clinical vision.

G. B.

## AS SHE IS WRIT.

*(This correspondence speaks for itself; the letters came to the Steward's Office.)*

**S**IR,—Somewhere about 25 years ago I was inpatient for few days because of forcing a catheter and breaking a small vein half way down Eureathea or can be reached by short fingers length up funderment. I have never had actual stoppage of urine, therefore the under doctor at your hospital gave wrong advise in ordering me to use catheter seeing my urine has always passed rather freely. The first trouble starting from this cause, I have been thinking your hospital ought to be the first to offer an attempt to heal. I was in patient in your hospital, but nothing was actually attempted at healing.

About five years ago I had one inoculation of 606, which has left a nasty pain at the spot in vein mentioned.

No discharge is seen from Eureathea or funderment but I know perfectly well I have a wound of some kind on the spot.

Between the legs is very soft, therefore a linseed poultice placed their for two hours daily by my own hand would make that part porous in time and draw on the said wound to ripen or loosen pus at that spot.

For some years I have adapted myself to having severe vapour baths for one to two hours with cold showers (not turkish baths).

This severe vapour heat has no doubt helped to keep me alive and in fairly good health, and such baths also help to act on the wound and spine to draw and remove internal matter.

For treatment I also propose a low diet, and injection to funderment of warm boracic or perman pot. A compostick of linseed solidified similar to iodoform stick for Eureathea could be pushed up funderment a few inches to dissolve or soften itself for healing and drawing without creating much pain or inconvenience.

I am fifty four years of age and am fairly robust and developed, therefore it is not like dealing with a worn out man.

But Ethea or Chloroform I must not have for reasons not necessary to state here. But I know there is chemicals now used which will deaden lower part of body if necessary to examine or open out funderment.

No attempt has yet been made to heal this wound, and the ideas proposed are comparatively harmless and of little risk. I have no blemishe on body of any kind, and consider stiff vapour baths with iodide of potassium more likely to cleanse a persons blood than a course of 606.

For instance years ago I had boils and rash at back of neck which any fool might have seen was syphilitic. Since I commenced these stiff vapour baths, I have never been troubled with these nasty syph boils or rash.

It is plain I cannot treat myself in my own place for the said catheter wound to hide the matter from my son. Hoping you will answer this letter soon as possible and offer to see what can be done for said wound. Your hospital has a good name, and I myself consider are more humane in manners and treatment than some hospitals.

I ask for no healing of stricture which is no trouble, the catheter wound midway in Eureathea is the one and only matter I ask may be healed, the trouble lays (actually) in the fundament. I send stamped addressed envelope for reply

Am yours respectfully

SIR,—I received your type-written letter, No matter where I have received type-written letters from on different matters, I always treat them with considerable contempt, a type-written letter to my mind, is like receiving a letter from a dummy with no brains and giving no confidence.

I also decline to be a gazing stock for your medical staff, and consider I have forgotten more than the whole bunch of them ever knew in *their* line of business.

I can tell your staff how to eat away the roots of cancers without pain. How to pass up an instrument to catheter wound complained of and spray it in a new fashion to purify that wound without pain, and the thing is *positive* but your *bold* letter in type written form has destroyed any intentions I had to do good. You persons are like the the gover-nment and Home-Office, You persons are too big for your shoes, I hope you do not run away with the idea I am some common cheap-jack. I could have told you how to take cataracts off the eyes painlessly and how in many or most cases paralysis can be healed.

The Home Office possess these secrets from me.

I decline to give them to your hospital, send me no more type written letters I have done with hospitals unless a more confidential style of letter *written* in ink is sent

Am Sir  
Yours truly

Isaiah

Fury to his adversaries, to the isles he will repay recompense.

## A PATIENT AT ST. THOMAS'S.

(Our readers will recollect that Mr. Tracey was wounded during the strike, and was taken to St. Thomas's Hospital.—Ed.)

**C**ON arriving at the patients' entrance of St. Thomas's Hospital I was carried in feet first (that I was not removed in the same fashion says something for the skill with which I was treated), and taken into the Casualty Box, where I had a number of things, but vaguely remembered, applied to various parts of my person. In the receiving-room I was divested of clothes and chattels; thence I was taken to the theatre, where, hoodwinked by a Clover's apparatus, I surrendered what remained of my personality.

Two days later, coming back to life in a small private ward, I was asked by the Sister if I was a teetotaller—the loss of two pints of blood had left me so thirsty, that I did not stop to wonder whether anything I might say would be taken down in evidence against me; however, my enthusiastic reply was not taken amiss, and the supply of drinks that followed would not have discredited an American bar.

Having made Sister's acquaintance, I turned my expert eye (for I have been warded in a dozen hospitals) to the nursing staff. Here I made an initial error: for some time I regarded those ladies who wore blue belts with much awe, only to hear one of them say, "I will ask nurse if you may have an air cushion instead of a water bed"; apparently Florence Nightingale ordained that probationers should wear the emblem of the Bart's staff nurses.

Florence Nightingale is the patroness saint of the St. Thomas's nurses, and she bequeathed to them her cap (a rather unbecoming one), and to the hospital her famous lamp; moreover she apparently arranges that the hospital shall have a sufficient supply of recruits, for there is always a "special" nurse forthcoming if one is needed for the particular welfare of any patient.

Later on, when I got to know them better, it gave me great joy to show them how to make a bed with the cunning of our own ladies—demonstrating the correct way of turning in the corners at the foot of the bed, and of arranging the pillows to simulate an armchair.

It is difficult to speak of the overwhelming kindness with which I was treated; numerous privileges were allowed me—privileges that upset the routine of the ward which is so dear to the heart of a good Sister (and mine was superlatively good), and so necessary for the efficient conduct of the ward.

However much a Bart.'s man may love the Square, it is impossible not to be envious of St. Thomas's supreme possession—the Terrace and the River.

The delight of getting out of the wards (long, light and airy though they are) on to the riverside, where one may watch the traffic coming in at the height of the tide; the everlasting fascination of London's river—"liquid history" in someone's fine phrase; the view of the river by day and night, in sunshine and moonlight—these make a host of unforgettable memories.

During the last week of my stay I lived entirely on the Terrace. I only went indoors for a bath and breakfast—and this took place at the hour of 8 a.m. instead of at 6 a.m., which is a patient's unfortunate lot in other hospitals.

Lying at night on the Terrace I, incidentally, enlarged my vocabulary. To listen to the coo of the gentle barge when his tug collides with a buoy or some frail racing motor launch is a liberal education. I count this not the least of my gains—already I have shocked and surprised more than one taximan.

I take off my hat in gratitude to this ancient and honourable foundation of St. Thomas's. Long may it flourish!

H. A. TRACEY.

## A VISIT TO HADES.

By THE FIFTH ASSISTANT TO ANY UNIT.

**I**T had for a long time been my ambition to visit Hades to gain a first-hand knowledge of the advance of medical science there, with special inquiry into the treatment of burns, in which subject the Hadesians are terrestrially presumed to have had exceptional opportunities for research.

A few months ago I was able to gratify my desire—perhaps you missed me. I am attempting in this little article to record a few of my impressions; my only excuse for so doing is that thereby I may induce some of my colleagues to make a similar trip. I am hopeful that some of them may be tempted to reside there eternally.

I chose the route across the Styx, first discovered by the Greeks, and more recently repopularized by Mr. Sutton Vane in his play *Outward Bound*. It is only fair to say that everything is done on the journey to make one comfortable; all meals are free, but for the benefit of American citizens it should be stated that drinks are extra, so that it is well to take more than a solitary *obolus* in one's mouth.

I cannot adequately described the enchanting scenery through which we passed, as there was not a Baedeker

in the ship's library. I spoke to Charon about this, and received the very interesting and welcome information that Herr Baedeker, on passing over, had commented on the same lack, and had received permission to make good the omission. Unfortunately for my readers, this great work is not yet completed; when finished it should give a great impetus to Stygian travel, and articles like mine will be made so much the more interesting by adequate splashes of local colour.

For those who suffer from *mal-de-mer* (and who does not in Stygian waters?) the long journey is unpleasant, and a Society has recently been started to promote the Erection of Bridges across the last Four Circles of the Styx. At the moment of your greatest distress the Steward invites you to subscribe to the Society. I became a Death-President.

It is, of course, the ever-present objection to foreign travel that foreigners are unable to converse with us in our native tongue; the English language is obviously the only medium of conversation for a civilized community, and it was a great disappointment to me that this had not been officially recognized in Hades. As a matter of fact the Customs official was a Bantu speaking West African, who failed entirely to recognize the distinction between a white skin and a black one. It is only fair to add that this was the only inconvenience I suffered during the whole of my very pleasant stay.

On producing my letters of introduction I was led at once to the house of a well-known medical man who entertained me lavishly during my stay; my own charm of manner soon put him entirely at his ease.

At dinner the same evening over the liqueurs I explained to my host the object of my visit. His reply, although slightly pontifical, seems to fit in so well with the mood of this article that I give it in full:

"You have come," he said, "to learn of our advances in medicine; had you thought for a minute you would not have done so. Here as you know there is disease, but no death. Here there is no marriage, and therefore no midwifery.

"What is the one thing that drives a man to undergo a surgical operation? The fear of death. Here, then, is no surgery.

"What is the one bright spot in the life of a physician?"

"His home?" I queried boldly, but without much hope.

He ignored the suggestion.

"Where is it that his wit is most scintillating, his sarcasm most caustic? Where is it that he experiences the joy of the hunter whose quarry never escapes him—the futile pleasure of the small boy who fails to solve his problem and turns to the end of the book for the solution?"

I like my metaphors as I like my drinks—unmixed. But I was silent, and he swept on.

"Where is it that his eyes light with the triumph of a diagnosis justified? Where is it that he sees the failure of his brother physicians and the mistakes of his brothers the surgeons?" (I thought in the half-light that his mouth twisted ironically at the word *brothers*.)

"The autopsy chamber," I cried, fearing that worse should come.

"Yes," he smiled, "no *mors*—no post-mortems; no post-mortems—no medicine. Ichabod!"

He sat silent for a few minutes and I was grateful for the brief respite; the fact that my arduous journey seemed to have been in vain overwhelmed me. I saw that any advantage that I had hoped to gain by my enterprise over my stay-at-home colleagues was almost entirely lost (even if they believed my story); I might as well have gone to Vienna or even to Holland for all the professional kudos my visit would give me.

I desperately played my last card.

"In one branch of therapeutics at least you must have outstripped us," I said. "How do you treat your burns?"

"Burns!" he cried, "Burns! There are no burns!"

My last illusion was swept away. What is Hell without a fire?

I perceived that I should have to devote myself to a study of the habits and political economy of the Hadesians, and it is on this subject that I propose to write ANOTHER HEAVY INSTALMENT NEXT MONTH.

(No, thank you.—EDITOR.)

## STUDENTS' UNION.

### CRICKET.

v. St. Albans, June 24th, at St. Albans.

The Hospital played a very weak side and were fortunate to score a total of 189. St. Albans treated the Hospital bowling with contempt and scored very quickly to gain an excellent victory. Result: St. Bart.'s, 189; St. Albans, 196 (3 wickets).

v. Hornsey, July 3rd, at Hornsey.

This match ended in a draw, greatly in favour of the Hospital; Bourne and Cook were largely responsible for the Hospital's total of 213. Result: St. Bart.'s, 213 for 9 wickets declared; Hornsey, 151 (9 wickets).

v. Moorcroft, July 7th, at Moorcroft.

The Hospital gained a rather easy victory by 5 wickets, Cook again making a large score. Result: St. Bart.'s, 183 for 5 wickets; Moorcroft, 74.

v. Past, July 10th, at Winchmore Hill.

As always, this match was very enjoyable despite the fact that the "Past" were not up to their usual strength. The Hospital, batting first, made the total of 224. The Past batting failed badly before Bettington's bowling, and were dismissed for 60 runs. Result: St. Bart.'s, 224; Past, 60.

v. St. George's Hospital, July 13th, at Chiswick House.

The Hospital were badly defeated in the semi-final of the Inter-Hospital Cup. Batting first on a damp wicket, Bart.'s were dismissed for 86, of which Bourne made 18. George's passed our score with 5 wickets in hand. Result: St. Bart.'s, 86; St. George's, 151.

v. Hampstead, July 17th, at Winchmore Hill.

This match ended rather tamely in a draw. Hampstead scored easily against a poor bowling side, and the Hospital had no difficulty in making a draw. Result: St. Bart.'s, 96 (4 wickets); Hampstead, 275 (5 wickets, declared).

v. Guy's 2nd XI.

In the semi-final of the Junior Inter-Hospitals Cup Bart.'s were badly defeated by Guy's. Result: St. Bart.'s 2nd, 101; Guy's 2nd, 213 for 7 wickets declared.

### UNITED HOSPITALS' ATHLETIC CLUB.

THE Annual Charity Contest in aid of the London Hospitals between the Banks, Hospitals, Stock Exchange and Insurance Offices for the *Financial Times* Challenge Shield was held at the Crystal Palace on Saturday, June 26th.

The meeting ended in a win for the Hospitals, who have now won the shield on two occasions to the Banks' three.

In spite of the Hospitals only being able to field a weak team owing to three of their "stars" competing in other meetings, they put up a fine performance, as was shown by the running of T. R. Griffiths, of Bart.'s, who won the 100 yards in 10½ secs., and was only beaten into second place in the 220 yards by inches, and G. C. Craner, of London, who won the quarter-mile in the excellent time of 52 secs. Other outstanding performances of the afternoon were those of V. E. Morgan (Stock Exchange), the old Oxford blue, who won the half-mile and 1 mile, and H. A. Johnson (Insurances), who won the 3 miles in 14 min. 47½ secs.

The result shows that were the United Hospitals Athletic Club well organized and on a sound financial footing, they would be able to field a team equal to the best in the country.

### RESULTS.

100 yards.—1, T. R. Griffiths (H.); 2, C. W. Gill (I.); 3, H. A. Mayer (S.). Time, 10½ sec.  
220 yards.—1, C. W. Gill (I.); 2, T. R. Griffiths (H.); 3, H. A. Mayer (S.). Time, 22½ sec.  
440 yards.—1, G. C. Craner (H.); 2, R. W. Emerson (B.); 3, K. G. Gudgeon (B.). Time, 52 sec.  
880 yards.—1, V. E. Morgan (S.); 2, R. C. Lightwood (H.); 3, J. H. Sanders (I.). Time, 2 min. 1 sec.  
1 mile.—1, R. D. Bell (I.); 2, V. E. Morgan (S.); 3, H. I. Price (B.). Time, 4 min. 34 sec.  
3 miles.—1, H. A. Johnson (I.); 2, J. M. Case (B.); 3, C. W. Baldee (I.). Time, 14 min. 47½ sec.  
Hurdles.—1, E. G. Miller (B.); 2, C. W. Harrison (H.); 3, M. W. Platel (H.). Time, 16½ sec.  
High jump.—1, A. R. James (I.); 2, E. C. Marsh (H.); 3, S. R. Druce (H.). Distance, 5 ft. 9 in.  
Long jump.—1, G. A. Clark (I.); 2, E. C. Marsh (H.); 3, W. Hartzog (H.). Distance, 22 ft. 5 in.  
Putting the shot.—1, W. Hertzog (H.); 2, M. Pietsch (B.); 3, G. Sturm (B.). Distance, 33 ft. 11 in.  
Relay race.—1, Insurances; 2, Banks; 3, Hospitals.  
Result.—Hospitals, 23 pts.; Insurance Offices, 20 pts.; Stock Exchange, 15 pts.; Banks, 14 pts.

## REVIEWS.

STUDIES IN INTRACRANIAL PHYSIOLOGY AND SURGERY. By HARVEY CUSHING, M.D. (Oxford University Press.) Price 8s. 6d.

Under the above title are assembled the Cameron Prize Lectures delivered at the University of Edinburgh in October, 1925. In these lectures Prof. Cushing deals, in his accustomed exhaustive and thorough manner, with the problems of the third (cerebro-spinal fluid) circulation and its channels, the pituitary gland as now known, and the surgery of intracranial tumours, dwelling particularly on his own experiences and the work of his younger associates.



The little book is a mine of detailed information, and the lectures contain the many references to matters of historical interest which are always a characteristic and attractive feature in this author's writings.

Every advanced student of anatomy and physiology should read the first two lectures, and the third should be inwardly digested by every physician. The lectures are beautifully illustrated with drawings and photographs, and the book is worth possessing merely for the bibliography.

THE HUMAN BODY AND ITS FUNCTIONS. By MARIE C. STOPES. SEX AND THE YOUNG. By MARIE C. STOPES. (Both published by the Gill Publishing Company.) Price 6s. 6d. net.

Rose Macaulay, in that delightful book *Orphan Island*, makes Mr. Thinkwell, the Cambridge don, when he hears the teacher of the children's physiology class saying "Very holy; very beautiful. A very wonderful arrangement of God's," exclaim, "What a curious notion! What is the idea in telling them that? Why not let them know at once what they will have eventually to know, that it is one of the very worst, silliest, most inefficient and most infernally inconvenient and dangerous arrangements in all nature? It is a positive disgrace to science that no better system has yet been devised. I fear these teachers of yours, like many of ours, are sentimentalists."

It is this sentimentality which spoils Marie Stopes's admirable work—it even obtrudes itself into *The Human Body and its Functions*, which is otherwise an excellent elementary text-book of physiology. Phrases such as "the immense richness and fragrance of the mental and spiritual sides of mature sex love," are out of place in a text-book—even the brain is referred to "as that soft and precious mass." All her work would profit by the use of a harsh and unsentimental blue pencil which has a positive distaste for luscious adjectives.

This having been said, her excellent books call for unstinted approval. It is interesting to learn in *Sex and the Young* that she is definitely opposed to special "sex instruction" in schools, but considers that it should be made a part of a complete physiological course—and this course she outlines in the companion book, *The Human Body*. There are minor details in both books which are not unexceptionable; it is a little difficult to see why the school staff library should include Marshall's *Physiology of Reproduction*, Westermarck's *History of Human Marriage*, and the *Lancet*; her suggestion that courses in chemistry, physics, botany, zoology, physiology and geology should be compulsory for every pupil in every school would upset an already overburdened curriculum. These are minor blemishes in her sincere and disinterested pioneer work.

MODERN METHODS OF FEEDING IN INFANCY AND CHILDHOOD. By DONALD PATERSON, B.A., M.B., M.R.C.P., and J. FOREST SMITH, M.R.C.P. (Published by Constable.) Price 7s. 6d. net.

Those who read this book to discover some new thing will be disappointed. It is a very comprehensive survey of the subject, but we have discovered nothing original in it. It deals very fully with the composition of infant foods, the various problems in breast and artificial feeding, and dyspepsias and constipation in infancy.

We know, however, that these subjects are adequately dealt with in modern text-books of midwifery and children's disease—and this book hardly seems to deserve its place in the excellent series *Modern Medical Monographs*.

NEURITIS AND NEURALGIA. By WILFRED HARRIS, M.D., F.R.C.P. (Oxford University Press.) Price 12s. 6d. net.

This monograph by the Senior Physician of St. Mary's embodies a vast amount of clinical experience. The scope of the work is indicated by the classification of nerve pain on p. 5.

The various types of peripheral neuritis are fully treated in the first part of the book. Among the interesting points one might mention the author's warning against the old standby, pot. iod., in the treatment of lead neuritis, and the difficulties of diagnosis to which the Argyll-Robertson pupil may give rise in these diseases.

In the section on neuralgias, the largest space is naturally devoted to trigeminal neuralgia, and much care is expended in detailing the various forms of alcohol injections, among which the author's own modification in injecting only the inner two-thirds of the Gasserian ganglion deserves special mention, as he claims by this means to leave the functions of the third division of the nerve unimpaired in the end. He is able to give as good a prognosis of cure with alcohol injection as with gasserectomy.

There is an interesting chapter on the path taken by the taste-fibres, embodying the original views of the author on a controversial subject, based partly on developmental findings, and considerable evidence is brought forward for his opinion that V is a gustatory nerve, as well as for the possible necessity of a correlation between the sensations conveyed by the lingual and chorda tympana nerves as a condition for normal taste appreciation.

Considering the detailed description of geniculate and glossopharyngeal neuralgia, it is surprising to find the subject of occipital neuralgia dismissed so briefly.

The author also describes a type of pain which he calls "migrainous neuralgia," by which he means a pain resembling paroxysmal trigeminal neuralgia, which is not improved by alcohol injection—an important contribution to our ideas.

He has scarcely touched upon the admittedly obscure subject of the vascular pains of angina type, which are, as some hold, fairly common causes of "neuralgia" even in the head.

The inclusion of the anatomy of the respective nerves in each chapter is a welcome feature and makes for easier reading.

RADIOTHERAPY IN RELATION TO GENERAL MEDICINE. By FRANCIS HERNAMAN-JOHNSON, M.D. (Oxford Medical Handbooks, Oxford (University Press.) Price 5s.

In the hands of the author, the subject loses all its terror and acquires a new fascination. Equipped with even the slender armamentarium of dimly remembered I.M.B. physics, the reader will find no difficulty in grasping the fundamental facts about the radiations in general, and X-rays and radium in particular.

He is led thence by well-arranged chapters, through the physiological and "pharmacological" action of the rays on the various tissues, to the consideration of their effects in disease, insistence being placed on the point of view that "there is no basis in either science or philosophy for any distinction between matter and energy."

The greater part of the book, very properly, deals with the subject of cancer treatment in its various aspects, and later with some other diseases, in which the author is not on such sure ground clinically.

The most stimulating side of the book is the general views expressed. Though naturally open to argument, they betray a breadth of outlook and a tolerance for all effective methods, even if they come from "unorthodox" sources. Great emphasis is laid upon the proper combination of all available forms of treatment, as against narrow specialism.

We can recommend this unpretentious though enthusiastic little volume to the practitioner as an aid in assessing the value of radiations in treatment, as well as in acquiring a new view of disease in terms of electrical variations. If only more people would think as synthetically as Dr. Hernaman-Johnson!

## RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ANDREWES, SIR FREDERICK W., O.B.E., M.A., M.D., F.R.C.P., F.R.S. "The Linacre Lecture on Disease in the Light of Evolution," *Lancet*, June 5th, 1926.

BOURNE, GEOFFREY, M.D., M.R.C.P. "Chronic Ulcerative Colitis in Children," *Archives of Disease in Childhood*, June, 1926.

BOYLE, H. E. G., O.B.E., M.R.C.S., L.R.C.P. "An Improved Anaesthetic Apparatus," *Lancet*, May 29th, 1926.

DALE, H. H., C.B.E., M.D., F.R.C.P., F.R.S. "The Biological Standardization of Insulin," *League of Nations Health Organization Reports*, April, 1926.

ECCLES, W. McADAM, M.S., F.R.C.S. "Salivary Calculi," *Clinical Journal*, March 31st, 1926.

FOOTE, ROBERT R., M.R.C.S., L.R.C.P. "Scurvy Simulating Acute Intussusception," *British Medical Journal*, June 19th, 1926.

FOULERTON, ALEXANDER G. R., O.B.E., F.R.C.S. "Bacteriology in Preventive Medicine," *Medical Officer*, July 10th, 1926.

GORDON-WATSON, SIR CHARLES, K.B.E., C.M.G., F.R.C.S. "A Case of Embolectomy," *British Medical Journal*, June 19th, 1926.

HADFIELD, GEOFFREY, M.D. (and HEWER, T. F.). "Achohric Icterus," *Lancet*, July 17th, 1926.

- HARVEY, FRANK, F.R.C.S. "A Pedunculated Thyroid Tumour at the Base of the Tongue." *British Journal of Surgery*, No. 52.
- KING, H. H., M.B., B.S. "The Stability of Solid Calcium Hypochlorite." *Journal Royal Army Medical Corps*, June, 1926.
- LISTER, A. E. J., M.B., B.S., F.R.C.S. "Diseases of the Eye." *Medical Annual*, 1926.
- LLOYD, E. I., M.B., B.Ch., F.R.C.S. (and SCHLESINGER, B. E., M.B., B.Ch., M.R.C.P.). "Four Cases of Immuno-Transfusion, with Remarks on the Method." *Archives of Disease in Childhood*, February, 1926.

## EXAMINATIONS, ETC.

### UNIVERSITY OF OXFORD.

The following degrees have been conferred :

D.M. and M.A.—W. V. Robinson.

B.M.—G. H. Crisp, K. A. Hamilton, O. R. Tisdall.

*First Examination for Medical Degrees.*

*Anatomy and Physiology.*—J. E. Jenkins.

*Final Examination for the Degree of B.M., B.Ch.*

*Materia Medica.*—H. P. Gilding.

*Pathology.*—H. E. Cuthbert, C. L. Harding, A. P. Kingsley.

*Forensic Medicine and Public Health.*—P. F. Cluver, G. H. Crisp, H. E. Cuthbert, C. L. Harding, W. H. Hudson, J. H. Kennedy.

*Medicine, Surgery and Obstetrics.*—G. H. Crisp, H. E. Cuthbert, J. N. C. Ford, K. A. Hamilton, W. H. Hudson, J. H. Kennedy, J. de la M. Savage, O. R. Tisdall.

### UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred :

M.Chir.—T. M. Thomas.

M.D.—A. J. Copeland, F. H. Young.

M.B., B.Chir.—P. O. Davies.

M.B.—G. L. F. Rowell.

### UNIVERSITY OF LONDON.

*Third (M.B., B.S.) Examination for Medical Degrees, May, 1926.*

*Honours.*—H. Simmonds (Dist. in Surgery).

*Pass.*—E. Bacon, R. T. Bannister, F. A. Bevan, H. C. Boyde, P. E. J. Cutting, T. D. Deighton, G. E. Ellis, D. B. Fraser, F. H. K. Green, R. H. Knight, N. Moulson, J. Parrish, H. N. Rose, B. M. Tracey, H. Treissman.

*Pass in Group I.*—B. M. C. Gilsenan.

*Pass in Group II.*—J. R. Beagley, W. R. W. Bonnor-Morgau, D. C. Fairbairn, O. F. Farndon, M. Fishman.

*M.D. Examination.*

*Branch I, Medicine.*—L. M. Jennings.

### SOCIETY OF APOTHECARIES.

The Diploma of the Society has been granted to the following :  
R. Lamort.

## CHANGES OF ADDRESS.

BEVAN, F. A., Compton, London Road, Hadleigh, Essex. (Hadleigh 60.)

OUSFIELD, E. G. P., 63, Wimpole Street, W. 1. (Langham 1634.)

BOYAN, Surg.-Capt. J., R.N., Meavy Lane, Yelverton, S. Devon.

BUCHLER, E., 112, Timbercroft Lane, Plumstead, S.E. 18. (Woolwich 0885.)

EBERLIE, W. F., Flint Cottage, Farley Hill, Luton.

HARRISON, S. G., 47, Muswell Road, Muswell Hill, N. 10.

HEPPER, J. E., Brechley, Kent.

HURRY, J. B., Heathlands, East Cliff, Bournemouth.

METIVIER, V. M., Cloak Room, St. Bartholomew's Hospital.

MORGAN, G. S., The Hermitage, Horsham, Sussex.

POLLARD, S. P., Meadhurst, Western Road, Leicester.

RICHARDSON, O., 71, Leigh Road, Eastleigh, Hants.

SHAH, B. Z., Capt. I.M.S., c/o Lloyds Bank, 6, Pall Mall, S.W.

SYMES, A. J., c/o Messrs. Grindlay & Co., 54, Parliament Street, S.W. 1.

## APPOINTMENTS.

BROOKE, C. O. S. B., M.R.C.S., L.R.C.P., D.P.H., R.C.P.S., appointed Junior Assistant Medical Officer, King George V Sanatorium, Godalming.

CULLINAN, E. R., M.B., B.S.(Lond.), appointed Assistant Medical Registrar, Westminster Hospital, London.

GIBBONS, G. F. P., M.B., B.S.(Lond.), appointed Hon. Assistant Surgeon, Kettering and District General Hospital.

KING, J. F. L., M.R.C.S., L.R.C.P., appointed Resident Medical Officer, Kent and Canterbury Hospital.

KITCAT, C. DE W., M.R.C.S., L.R.C.P., appointed Resident Medical Officer, Hospital for Consumption, Brompton, S.W. 3.

MELLOWS, P. B., L.M.S.S.A., appointed Resident Medical Officer, Hove Hospital, Sackville Road, Hove.

WOODMAN, E. MUSGRAVE, M.S., F.R.C.S., appointed Lecturer on Diseases of the Throat and Nose, University of Birmingham.

## BIRTHS.

BENJAFIELD.—On July 20th, at 29, Church Street, Edmonton, Georgina (née Blake), wife of Dr. Norman Benjafield—a son.

CHAPMAN.—On June 29th, at Wingmore Lodge, Wokingham, Berks, to Dr. and Mrs. E. F. Chapman—a son.

CURRIE.—On July 1st, at 107, Eastbourne Road, Darlington, co. Durham, to Mary Campbell Vickers, wife of Dr. John Currie, D.S.O.—a son.

STURTON.—On July 17th, at Aba, Belgian Congo, the wife of Clement Sturton, F.R.C.S.—a daughter.

## MARRIAGES.

FARR—CAPPER.—On July 10th, 1926, at Holy Trinity Church, Brompton, by the Rev. Prebendary Isaacs, Vicar of Cripplegate, assisted by the Rev. Prebendary Gough, Valentine Francis, M.B., B.Sc.Lond., youngest son of Dr. and Mrs. Ernest Farr, of Ealing, to Margery Baylis, younger daughter of Mr. and Mrs. H. W. Capper, of Harvard Road, Gennersbury.

HECKFORD—DADD.—On July 1st, at All Saints' Church, Woodford Wells, by the Rev. J. P. R. Rees-Jones, M.A., assisted by the Rev. W. M. H. Wathen, Frank Heckford, M.R.C.S., L.R.C.P., only son of Mr. and Mrs. Ernest Heckford, of Thrapston, Monkham's Drive, Woodford Green, Essex, to Gwendolen Louise, eldest daughter of Mr. and Mrs. F. W. Dadd, of Polmennor, Snakes Lane, Woodford Green.

PELLIER—ROCHE.—On July 10th, Charles de Chanval Pellier, of Highleigh, Teignmouth, to Dorothy, widow of Captain Thomas Roche, M.C., and younger daughter of Ernest Hatton, Barrister-at-Law, and Mrs. Hatton, 2, Cross Park, Teignmouth.

## SILVER WEDDING.

PATERSON—FABER.—On July 13th, 1901, at St. Paul's, Beckenham, Herbert John Paterson, of 9, Upper Wimpole Street, W., to Tempe Langrish Faber.

## DEATH.

MOSTYN.—On June 22nd, 1926, in a motor car accident, Sydney Gwenffrwd Mostyn, M.B., B.Ch.(Oxon.), D.P.H.(Camb.), Medical Officer of Health for Darlington, aged 59.

## NOTICE.

*All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C. 1.*

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